

# **The California Commission on Health and Safety and Workers' Compensation**



## **Summary of December 7, 2006 CHSWC 24-Hour Care Roundtable**

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**Allen Davenport**  
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**Darrel "Shorty" Thacker**  
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### **Executive Officer**

**Christine Baker**

**State of California**  
**Labor and Workforce Development Agency**  
**Department of Industrial Relations**

**April 27, 2007**

# Summary of December 7, 2006 CHSWC 24-Hour Care Roundtable

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# Summary of December 7, 2006 CHSWC 24-Hour Care Roundtable

## Background

Suggestions have been made to more closely coordinate or combine workers' compensation medical care with the general medical care provided to patients by group health insurers in order to reduce overall administrative costs and derive other efficiencies in care. Research supports the contention that a 24-hour care system could potentially provide cost savings as well as shorten disability duration for workers. (See *Attachment A* for a listing of information resources on 24-hour care.)

Studies on 24-hour care by the Commission on Health and Safety and Workers' Compensation (CHSWC) and RAND describe the consolidation of health care benefits and, possibly, disability benefits for both work-related and non-work-related claims. These health care services could be delivered by the same group of providers under coordinated insurance package(s).

The CHSWC study looked at states that have adopted 24-hour care legislation and have held pilots. At least ten states have adopted legislation permitting 24-hour care pilots. Since then, pilot programs in five states were attempted and examined in research. Only two states, Oregon and California, succeeded in making the pilots operational. The results, benefits and barriers of the California pilot, called "Kaiser on the Job," were documented in a 2003 CHSWC study.<sup>1</sup>

The RAND study looked into legislative and legal issues of 24-hour care program systems and components. The study included focus groups of stakeholders in California who shared views on the potential value, barriers and incentives of adopting such new models. Finally, recommendations for a pilot program were made, with specific criteria about eligible participants, design options and robust evaluation capabilities.<sup>2</sup>

These two studies suggested that an integrated 24-hour care benefits program offers the potential to improve efficiency in claims administration, reduce overuse of workers' compensation-based health services through care management, and reduce health care costs. However, not all of these benefits have been proven in practice, due partially to measurement difficulties and the limited and inconclusive nature of the pilot programs ("failure to scale").<sup>3</sup>

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<sup>1</sup> CHSWC Background Paper: Twenty-four Hour Care, December 2003.  
[http://www.dir.ca.gov/CHSWC/CHSWC\\_24hCare.pdf](http://www.dir.ca.gov/CHSWC/CHSWC_24hCare.pdf)

<sup>2</sup> RAND. Assessment of 24-Hour Care Options for California, 2004.  
<http://www.dir.ca.gov/CHSWC/Reports/24HourCare.pdf>

<sup>3</sup> RAND, p. xix and p. 30.

## **Summary of December 7, 2006 CHSWC 24-Hour Care Roundtable**

At the request of CHSWC 2006 Chair Angie Wei, CHSWC staff held a 24-Hour Care Roundtable meeting on December 7, 2006, in Oakland, to provide an update on the state of 24-hour care programs, to discuss the operational and technical aspects of a 24-hour care system, and to investigate the options for integration, such as integrating health care services or integrating health care services with both group health insurance and workers' compensation insurance.

The roundtable included 26 stakeholders in the workers' compensation system representing insured and self-insured employers, labor, insurance carriers, and medical providers. (See *Attachment B* for the Roundtable Agenda and *Attachment C* for a listing of the participants.)

Discussion centered on identifying the current issues and challenges with respect to 24-hour care in California:

- Successful models in other states, as well as in California.
- Challenges to implementing a 24-hour care system.
- Recommendations and objectives when moving toward a 24-hour care system such as implementation in the public sector, voluntary participation with incentives in the private sector, and within carve-outs.

### **Introduction**

Angie Wei, 2006 CHSWC Chair, welcomed the participants and thanked them for taking the time to discuss the issues. She acknowledged that not all participants had the same level of experience with the issues of 24-hour care and expressed her appreciation for the opportunity to talk about it with a broad range of experts and stakeholders. She admitted that health care reforms were on the legislative agenda for 2007 and added that universal health care could be on the agenda as well. She explained that CHSWC wanted to take advantage of the opportunity to seriously discuss moving towards 24-hour care.

Chair Wei stated that health care integration could provide significant benefits because it could potentially minimize duplication and errors, save costs, and improve quality of care for workers injured on or off the job. She asked all the participants to take a longer view than the current legislative session and to consider a time frame as distant as ten years. She challenged the participants to imagine how they wanted the health care system in California to function with improved outcomes and quality of care.

The meeting continued with introductions by all participants followed by three presentations on background and research on 24-hour care.

### **Summary of Background and Research Presentations**

*An Employee-Centric View of Workforce Health and Productivity*  
**William Molmen, Integrated Benefits Institute**

William Molmen, General Counsel of the Integrated Benefits Institute (IBI), provided an overview of studies and surveys on integrated care. The presentation focused on ways that healthcare plays an important role in the cost structure and bottom-line workforce productivity of a business. IBI has measured and benchmarked this issue in a number of studies which were discussed.

A 2002 study by IBI looked at the national level for 87 participants in IBI's full-cost benchmarking program and found that employee group health is the largest program in terms of benefits payments for employer participants, while workers' compensation is a relatively smaller program. Group health accounts for an average of \$3,090 per full-time employee (FTE), whereas workers' compensation accounts for an average of \$435 per FTE. However, these facts are not universally understood by employers, since few keep all of their benefits program payments in a single place.

Employers also do not always understand that injuries and illnesses create lost productivity costs and that lost productivity results in much larger costs to the employer than paid benefits. Mr. Molmen stated that IBI uses a "lost-productivity multiplier model" to calculate total costs from absence. On the two extremes, employers either rely on excess staffing to cover absences or lose revenue from the absent employee. For most employers, it is impossible to know who will be out on a given day in order to have a replacement standing by. In addition, employers cannot afford to lose revenue due to absence. The true cost of absence is somewhere in between. The "multiplier model" approach, used by IBI and developed by Sean Nicholson from Cornell University, looks at the continuum of the above approaches, such as the inability to find a perfect replacement worker, the "teaminess" or collaborative nature of the workplace, and the price of revenue due to falling output. He calculates a multiplier for a number of occupations, which IBI averages out as 1.4 times the cost of the absent employee's wages and benefits.

Using such models reveals the significance of unscheduled absences and where unexpected costs reside. Once the true costs of absences are identified, health issues can be looked at from a different perspective. For example, the HPQ study by Ron Kessler of Harvard Medical School looked at the conditions that drove "presenteeism," which is defined as an underperforming workforce which is at work but not fully productive because of health-related conditions. The results of the Kessler study indicate that the majority of the costs to employers are related to presenteeism. The health-related costs of injured workers in the workplace may be due to injured workers returning to work but not getting the correct treatment, or perhaps ignoring their doctor's advice, or having injuries and illnesses that are untreatable and therefore they are not functioning as well as they should be. The key point here is that the lost-productivity effects of absence (and presenteeism) greatly exceed benefits payments in the various programs. By the same token, the savings available from interventions vastly outweigh any savings in benefits payments.

A survey in 2004, reported in 2005 by IBI, asked employers about healthcare costs. Employers replied that they were using two approaches: shifting responsibility and costs to workers; and promoting health. Employers also replied that in the future, only 15% of employers would continue to try to minimize costs year-to-year. However, 61% of employers said that they want to manage the burden of ill health by managing absence, disability and productivity. Another

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IBI survey in 2006 of Chief Financial Officers (CFOs) revealed that almost 50% believe that absenteeism and presenteeism already have a meaningful effect on their company's business performance. These survey responses indicate that employers have an enterprise-wide, employee-centric view and are moving away from managing benefits in silos.

A seminal study in 1994 by the California Workers' Compensation Institute (CWCI) compared group health with workers' compensation medical treatment in California, looking at about 70,000 claims from each of the systems from the years 1990-1991. Results showed that workers' compensation costs and utilization were higher than in group health, but that workers' compensation medical treatment duration was much shorter than in group health. If the duration of temporary disability also was short, then this study is evidence of the efficacy of a sports-medicine approach in workers' compensation. The effect of higher utilization on disability durations was not clear, because disability results were not available. In 1996 research, IBI did find that a sports medicine model (intensity of medical treatment) was a significant factor in pre-maximum medical improvement (MMI) release to work and that the employer's culture and attitudes were another key but unmeasured part of the research.

An IBI study utilizing a survey of physicians conducted by Cornell University in 2002 captured the physician's viewpoint. Almost all physicians surveyed agreed that return to work (RTW) should be part of treatment. Functional assessments were also commonly considered part of the treatment. However, it was found that physicians usually will release an injured worker to return to work when an employer asks them to do so. It was also found that culturally, patients expect to be off work when it is a workers' compensation claim. In addition, an Intracorp/CIGNA study from 2001 looked at days off work by occupation for both workers' compensation and non-occupational patients. In general, workers' compensation patients stay off work much longer than non-occupational patients. Employee dissatisfaction with the disability process also tends to be higher in workers' compensation. These two studies suggest that the current workers' compensation system may not serve the best interests of the employer or the employee.

A 1998 IBI report focused on a Pacific Bell pilot which involved four health plans, including Kaiser, based in Orange County, California. The health plans in the pilot were used by injured employees to determine compensability for and to treat workers' compensation injuries. The pilots required the health plans and Pacific Bell to heavily manage their workers' compensation cases and allowed the employees to go to their non-occupational healthcare plan. Some plans put occupational medicine doctors in place; other plans allowed people to see their primary treating physician with referrals to specialists as needed. Each plan was required to have a nurse case manager, the third-party administrator (TPA) had a case manager, and RTW and disability management were stressed by Pacific Bell as part of the pilot. The greatest challenge in the pilot was getting risk management and human resources functions at Pacific Bell to agree that a single doctor should make the disability determinations for both workers' compensation and the short-term disability (STD) supplementary benefit.

Results from the Pacific Bell pilot indicate that there was a significant decrease in all cost factors and an improvement in patient satisfaction. The decrease included cost-per-case reductions of 29%, average temporary disability (TD) cost reductions of 41%, average days lost reductions of 34%, percent of lost-time cases reductions of 32%, and reductions in claims denied (anecdotally)

and in litigation. Workers appeared to be satisfied with the program and seemed to go through it more quickly than in non-integrated systems. In terms of medical results, decreases were seen in costs, duration, number of physician visits and number of medical procedures, and an increase was seen in the number of medical procedures per visit. Physicians were able to provide early medical treatment more effectively than in other systems. The conclusions from the pilot included that: patient satisfaction is the key to results; communication is critical; injured workers stayed within the networks; fewer cases were denied; the primary care physician (PCP) needs access to expertise and case management; and start-up investment in training of medical care providers is needed to ensure success.

IBI also surveyed over 100 employers for an integrated benefits best-practices survey, 77 of whom had integrated disability-management programs covering workers' compensation and short-term disability programs. The survey indicated that the best practices for an integrated system included: transitional RTW; strong integrated case management; common claim intake; and comprehensive communication.

Conclusions from the pilots and surveys discussed were that the key is to create an employee-centric model of an integrated health system, which treats the whole employee not the specific injury, and leads to greater productivity. This will create a win/win situation for employers and employees.

IBI research publications are available at: [www.ibiweb.org/publications/research](http://www.ibiweb.org/publications/research)

#### ***24-Hour Coverage: How Can We Get There From Here?***

##### **Mark Webb, Employers Direct Insurance**

Mark Webb, Vice President, Governmental Relations, Employers Direct Insurance, focused on the federal Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), and traditional institutionalized healthcare delivery products. His presentation raised many questions and issues including: reconciling the differences between an employer-mandated system, such as workers' compensation, and an employee-paid system, such as group health; options for implementing 24-hour care without implicating ERISA; and 24-hour care health and disability products.

The California Labor Code prohibits employee contributions in the workers' compensation system and mandates that costs must be fully paid by employer. Similarly, carve-outs do not allow cost sharing. Medical treatment, utilization review and dispute resolution processes are currently different in workers' compensation than in group health. Provider compensation issues, such as the Official Medical Fee Schedule (OMFS), liens and the medical-legal fee schedule, would have to be reviewed. Federal law also impedes state-designed 24-hour care programs. ERISA governs employee benefit plans; even if a plan is voluntary, it means that it is voluntary to the employee and not sponsored by the employer; if it is an ERISA plan, then the employer cannot contribute.

Mr. Webb stated that the outcomes of past 24-hour care pilot projects were inconclusive. Discussion of coordination vs. integration weighs heavily on current legal, political and

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institutional hurdles that need to be cleared (for example, litigation in Maine over 24-hour care). In California, evaluation of a 24-hour pilot concluded that more outreach to employees would be needed but recognized that ERISA preempts such activities. Finally, HIPAA might apply if both systems were truly integrated, and that would result in questions of who owns patient data.

Additional issues raised included the question of payment, for example, whether the employer at the time of injury will still be responsible for the entire costs of a workers' compensation claim even if the employee changes jobs following an injury or illness.

Workers' compensation policy objectives could be affected by 24-hour coverage and this raises questions such as:

- Will broader spreading of risk reduce safety incentives? Will medical costs still be captured for purposes of experience rating? How do various models for determining health care premiums (not based on occupational classification) shift the equities in the workers' compensation system?
- How could risk-adjusted rates affect safety incentives for small employers? (See Insurance Code Section 10714 relating to premium calculations for small-employer health plans.)
- Will RTW initiatives be more difficult to implement if the treating physician is not immediately aware that the injury or illness is occupational?
- To what degree will the workers' compensation "infrastructure" still need to be maintained regarding injury and illness reporting to Cal/OSHA?
- How will special programs be maintained (e.g., asbestosis)?

Mr. Webb also discussed coordination of disability programs. The question was raised if the current medical provider network (MPN)/utilization review (UR)/Medical Treatment Utilization Schedule (MTUS)/medical-legal structure is the best way to maximize both outcomes and efficiencies. Private carriers are already integrating short-term disability (STD)/long-term disability (LTD)/workers' compensation programs where the insurer has a disability and workers' compensation certificate of authority or pursuant to joint marketing opportunities. STD/LTD may or may not be covered by ERISA given that the programs are coordinated rather than integrated.

It was pointed out that California is unique in that the State is exempt from ERISA and is legally uninsured for workers' compensation. This allows for far greater flexibility in fashioning benefit programs. The State is already offering private sector-administered, voluntary LTD programs where benefits are offset by workers' compensation, social security, and other payments including CalPERS and CalSTRS disability retirement income. A program is offered for excluded employees. As a result of these factors, if a pilot project is to be considered, it would be better to conduct it in the public sector.

The presentation concluded with several questions:

- What are the objectives of 24-hour care?



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- What does a 24-hour care medical system eliminate in terms of costs when there is still an obligation on the part of the employer to provide lifetime benefits, a need to make specific determinations for the purposes of disability evaluation, and a need to maintain two sets of medical records to address privacy concerns under HIPAA?
- Would a 24-hour care system mean that occupational medicine is no different from non-occupational medicine or that both can be embraced in the concept of “medical necessity”?
- Would a review of current laws governing workers’ compensation medical treatment result in recommendations that further the goals of providing prompt quality medical care without raising preemption issues?

### ***Integrating Occupational and Non-Occupational Health Care*** **Christine Baker and Lachlan Taylor, CHSWC**

The presentation by CHSWC Executive Officer Christine Baker and Judge Lachlan Taylor emphasized the benefits of 24-hour care and several options for an integrated system, as well as ways to address barriers to establishing a 24-hour care system.

*Benefits of 24-hour coverage could potentially include:*

- Improved quality and coordination of care:
  - Elimination of duplicative medical procedures, such as diagnostic tests.
  - Elimination of uncoordinated and potentially incompatible treatments, such as medications.
  - Improved communication between physicians and other health care professionals.
- Lower overall medical expenditures.
- Reduction in administrative costs of the two systems:
  - Definition of “appropriate care” is consistent in both systems.
  - Fewer disputes and delays over treatment.
  - Less litigation.
- Savings for employers and improved affordability for workers.

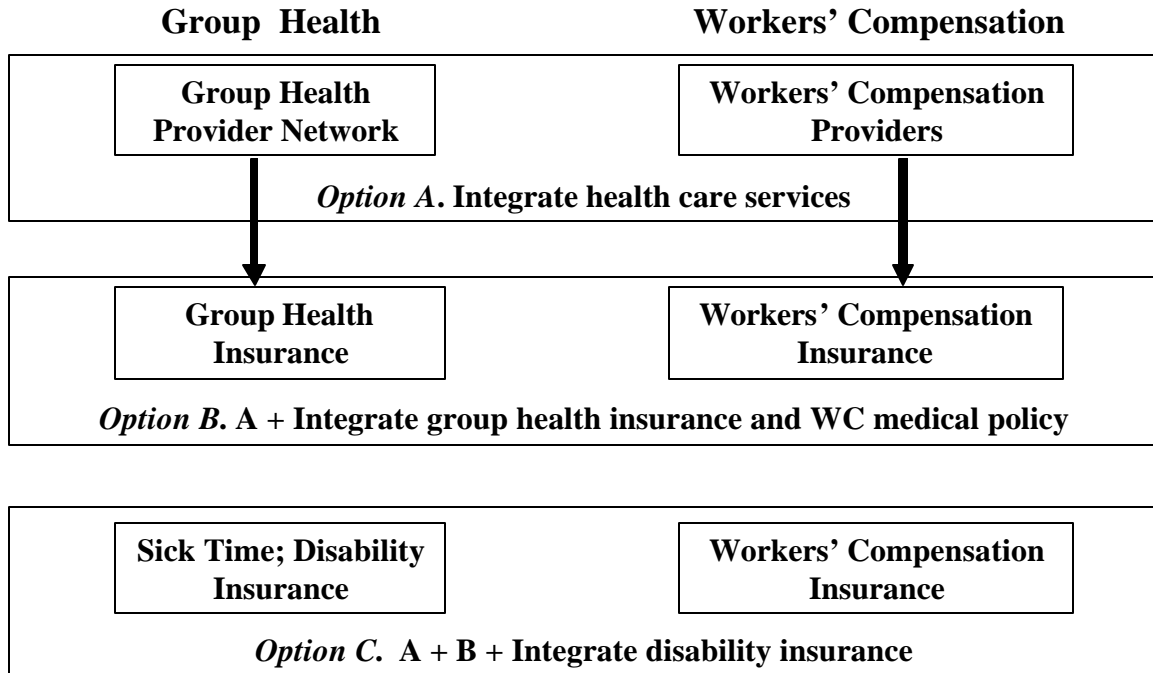
### *Options for an Integrated System*

*Option A:*      Integrate health care services

*Option B:*      *Option A* + integrate group health insurance policy and workers’ compensation medical insurance policy

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*Option C:*     *Option A + Option B + integrate disability insurance (disability integration is not subject to discussion in this roundtable.)*



### *24-Hour Care System: Potential Barriers*

- ERISA.
- Differences between occupational and non-occupational health care.
- Availability and affordability of group health insurance.

### *ERISA*

- Under ERISA, the U.S. government regulates private sector, employer-based pension plans and welfare plans that include health insurance and other types of benefits.
- An exemption in ERISA allows states to regulate employer-provided benefits that are intended solely to comply with workers' compensation laws, but states are not permitted to regulate private sector, employer-based plans offering general health care for non-occupational medical conditions.
- Addressing ERISA barriers:
  - Focus on voluntary integration.
  - Enable all private sector employers to integrate both occupational and non-occupational health care services, but keep health insurance and workers' compensation insurance policies separate.

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- Enable private sector employers to voluntarily integrate both occupational and non-occupational medical services and workers' compensation insurance and group health care insurance policies.
- Focus on public sector employers because they are not regulated by ERISA.
- Evaluate consequences of complying with ERISA.

### *Differences Between Occupational and Non-Occupational Health Benefits*

- Workers' compensation covers medical benefits for claims based on date of injury without a specific time limit on medical services, whereas general health insurance pays for medical services that are provided during the policy period.
- Workers' compensation usually involves full payment by the employer for required treatment, whereas general health insurance usually requires the individual to share in premium costs and pay co-payments and/or deductibles.
- The two systems have different criteria for necessary tests and appropriate treatments and methods to resolve medical treatment disputes.

### *Not All Workers Have Group Health Insurance*

- Nearly one half of all Californians are ineligible for employer-based group health insurance, either because their employers do not offer health insurance as a benefit or the individual is unemployed.
- Additional workers do not participate in available group health plans because the cost is too high.
- Group health insurance is not available or affordable to all workers.
- Addressing group health barriers:
  - Focus on voluntary integration.
  - Integration could provide incentives for employees and employers to participate in group health by making it more affordable.
  - Can incentives be sufficient?

## **Roundtable Discussion Points**

Following the presentation, roundtable participants raised the following key issues:

- **Cost of Injuries and Illnesses**

The workers' compensation system does not currently look at the total costs. Productivity costs are at least as important as medical costs. Employers need to calculate or understand how absenteeism and presenteeism relate to the enterprise as a whole. A review of total costs of injuries and illnesses might shift responsibilities away from managing in silos to combining absence, disability and productivity issues.

- **Disputes**

Disputes about treatments and ratings should be reduced and savings captured.

- **Employee-Centric Model**

An employee-centric model would treat the whole employee, not the specific injury. The goal of the model would be to create a win/win for employers and employees.

- **Legal Challenges**

Legal challenges include federal legislation, particularly ERISA and HIPAA. Federal ERISA is a present barrier, and an integration model would have to receive a legal exemption. A pilot would have to be conducted in a currently exempted pool, such as the State of California. If it becomes a mandated program, ERISA would not apply. Federal HIPAA might apply to an integrated system and is part of the administrative burden of a non-integrated system.

- **Administrative Challenges**

HIPAA protections might apply to all patient information, including workers' compensation reporting, possibly requiring two sets of medical records for the purposes of disability evaluation.

From the provider perspective, the differences in medical care between occupational and non-occupational medicine are the reporting requirements. For example, the reason people get sent to occupational health as a specialty is that employers and payers are waiting for reports. The majority of non-occupational physicians are not given adequate time to handle that reporting, and they are not trained in permanent disability (PD) reporting. In addition, the lack of uniformity in documenting information is also a challenge. Keeping up with what the payers want is difficult, especially because requirements keep changing.

Paperwork should not have to stand in the way of treatment and the individual and the employer. That process needs to be taken care of outside of the treatment window and be handled in a way that would integrate several aspects of the administrative process that are not currently integrated. The liability could go to some delayed action, such that within 60 days, it would be decided whether or not the injury or illness was industrial, but in the meantime, the treatment would be started.

- **Environmental/External Factors**

Nearly 50% of Californians do not have group health insurance, either because their employers do not offer health insurance as a benefit or the individual is unemployed. Additional workers do not participate in available group health plans because the cost is too high. It will be important to consider the effect of an integrated system on benefits if only half the population is covered by group health.

- **Policy**

Integration would need to preserve the incentives of creating a safe workplace. The issue of RTW would need to be at the forefront. The treating physician should be aware that the injury or illness is occupational and that return to functionality is a priority. Ultimately, the distinction between occupational and non-occupational medicine, if any, would have to be decided.

Incentives need to be carefully reviewed. For example, if the reimbursement rate for group health and workers' compensation is different, cost shifts or provider shifts may be inevitable. PD, as another example, drives indemnity incentives, including medical incentives. The injury of multiple body parts will maximize the PD rating, leading to some medical treatment that would never be permitted in a group health system.

Reporting requirements to Cal-OSHA would need to be coordinated or otherwise captured. This issue was raised; however, OSHA sample collection would continue regardless of the system.

The distribution mechanism of healthcare products usually requires licensing brokers and agents, so the delivery of coordinated products might complicate the current process.

Cost drivers and friction costs need to be analyzed. A small number of claims account for a large proportion of the costs. A common appeal process would eliminate friction. 80% of costs are medical-only, without medical friction. The other 20% could be treated differently, via another path, such as speed tracking, etc.

An emphasis by the employer community on functional restoration and RTW would create an environment for broader access to healthcare.

- **Models**

It was suggested that healthcare may operate in an integrated fashion more in spite of the system than because of the system.

- **Option A** (integrate health care services).

Some people believe that this model is already in place through pre-designation and because workers' compensation providers are held to Knox-Keene rules which regulate health care maintenance organizations (HMOs).

Further, adoption of MPNs was a decision to adopt the group health model. The challenge would be to make integration more explicit/intentional for all parties.

- **Option B** (integrate A with both insurance policies).

- **Option C** (integrate A + B + disability insurance).

This model was viewed as a useful option to allow measurement of total costs in the system.

## **Roundtable Recommendations**

### ***Short-Term Objectives:***

- Coordinate existing administrative functions, forms and reporting requirements through common intake, common integration of processes, including the RTW process and case management, and a common appeal process.
- Identify to what extent the current system fits Option A and what could be modified to fit the model. Currently, some people believe that we are already approaching Option A as workers' compensation medical services are integrated through provisions such as predesignation and medical provider networks (short-term objective).
- Gather statistics and data that would include:
  - The number of workers who are covered through employer-based group health and who are not covered, as well as the demographics of these workers.
  - The number of workers of large vs. medium vs. small employers who are covered by group health.
  - The number of people who need to seek treatment for the long-term and the cost of this treatment.
  - The number of people who change employers and/or plans.
  - The number of people who need to seek treatment out of state and the costs involved.
  - Employer demographics, such as percentage of employers with 500 or more employees, number of employers with up to 10 employees who do not offer health benefits, and the percentage of employees without benefits who could potentially be helped by a 24-hour care system.
- Consider potential avenues to implement 24-hour care:
  - Within carve-outs.
  - In the public sector, where ERISA preemption will not be an issue.
  - Consider piloting 24-hour care in the public sector.

### ***Long-Term Objectives:***

- Resolve frictional costs. Option B, which looks at integrating insurance plans as well as medical services, will lend itself to discussion of how to resolve frictional costs and what types of dispute resolution mechanisms need to be put in place.
- Maintain a perspective that incorporates all system costs.
- Consider the following areas:
  - Incentives or reimbursements to providers in order to avoid cost shifting.
  - Additional statistics and data:

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- The total outcomes to the system from both medical/disability and productivity to determine what the total costs to the system would be if 24-hour care were not implemented.
- The type and quantity of physical medicine that are provided under workers' compensation compared to group health.
- The decrease in claims which may be caused by workers' compensation claims being shifted into group health.
- The performance and dynamics of Labor Code 5402 (90-day/\$10,000 cap).
- Analysis of other models:
  - The Health Care Organization (HCO) model which has elements of the group health model, especially the internal dispute resolution system and quality assurance.
  - Programs in other states, especially Oregon and Washington.

### **Meeting Conclusion**

The meeting concluded with the understanding that all input from participants would be collected for continued review of technical adjustments to and broader systemic challenges of 24-hour care.

CHSWC Executive Officer Christine Baker thanked the attendees for their contributions to and participation in the CHSWC 24-Hour Care Roundtable.

*Attachment A*

**Information Resources on 24-Hour Care**

California Department of Managed Health Care. “Potential Benefits and Obstacles to the Integration of Workers Compensation Insurance with Employer Purchased Health Benefits,” August 2005.

California Health Care Foundation (CHCF). “Snapshot, California's Uninsured 2006.”  
<http://www.chcf.org/documents/insurance/CAUninsured06.pdf>

Commission on Health and Safety and Workers’ Compensation “CHSWC Background Paper: Twenty-four Hour Care,” December 2003.  
[http://www.dir.ca.gov/CHSWC/CHSWC\\_24hCare.pdf](http://www.dir.ca.gov/CHSWC/CHSWC_24hCare.pdf)

CHSWC Annual Report, 2005.  
<http://www.dir.ca.gov/CHSWC/Reports/AnnualReport2005.pdf>

Integrated Benefits Institute (IBI) research publications  
[www.ibiweb.org/publications/research](http://www.ibiweb.org/publications/research)

RAND. “Assessment of 24-Hour Care Options for California,” 2004.  
<http://www.dir.ca.gov/CHSWC/Reports/24HourCare.pdf>  
or <http://www.rand.org/pubs/monographs/MG280/index.html>



*Attachment B*

**CHSWC 24-Hour Care Roundtable Meeting Agenda**

**Date:** Thursday, December 7, 2006

**Time:** 10:00 am – 1:00 pm

**Place:** Elihu Harris State Building  
1515 Clay Street, 2<sup>nd</sup> Floor, Room 15  
Oakland, CA 94612

I. Introductions

Angie Wei, Chair, and Christine Baker, Executive Officer, CHSWC

II. Background and Research

William P. Molmen, General Counsel, Integrated Benefits Institute (IBI)

Mark Webb, Vice President Governmental Relations, Employers Direct

CHSWC Presentation: Christine Baker and Lach Taylor, Staff Judge

III. Discussion

Barbara Wynn, Senior Health Policy Analyst, RAND

IV. Next Steps

*Attachment C*

**CHSWC 24-Hour Care Roundtable Participants**

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Lynn Keller  
Bickmore Risk Services

Mark Sektnan  
AIG Claim Services

Mark Webb  
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Moira Topp  
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Peggy Sugarman  
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Reubens

Scott Hauge  
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Small Business California

Tim Hoops  
Blue Cross

William Molmen  
Integrated Benefits Institute

William Zachry  
Safeway

**CHSWC Consultant**

Juliann Sum, UC Berkeley

**Facilitator**

Barbara Wynn, RAND

**Summary of December 7, 2006 CHSWC 24-Hour Care Roundtable**